EMPLOYEE ACKNOWLEDGMENT OF DDSN DRUG AND ALCOHOL TESTING POLICY

EMPLOYEE NAME: _____

SOCIAL SECURITY NUMBER:_____

WORK LOCATION (CENTRAL OFFICE/DISTRICT OFFICE/REGIONAL CENTER: _____

My signature indicates that I have received a copy of this policy, read and/or been briefed by _____ and understand the S.C. Department of Disabilities and Special Needs (DDSN) Drug and Alcohol Testing Policy.

I understand that any violation of this policy will be grounds for immediate disciplinary action up to and including dismissal.

_____ _____

Employee Signature Date

_____ _____

DDSN Representative Date